

[Insert Logo Here]

DETAILED EXPLANATION OF NON-COVERAGE

Date:

Patient Name:

Member ID Number:

Because you requested an appeal, you are receiving this detailed explanation of why your M+C plan believes your Medicare coverage for *{insert type}* services should end. **This notice is not the decision on your appeal.** The decision on your appeal will come from your Quality Improvement Organization (QIO).

- **We have reviewed your case and decided that Medicare coverage of your *{insert type}* services should end.**

{Insert relevant text about who made the decision}

- **The facts used to make this decision:**

{Insert relevant text}

- **Detailed explanation of why your services are no longer covered under your M+C plan, and the specific Medicare coverage rules and policy used to make this decision:**

{Insert relevant text}

- ***{Insert M+C plan}* policy, provision, or rationale used in making the decision:**

{Insert relevant text}

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at *{insert M+C plan or provider telephone number}*: